SECTION 460 REPORT
April 15, 2006

Background
P.A. 154 of 2005, the Appropriations Bill for The Michigan Department of Community Health (MDCH), contained boilerplate language in Section 460 requiring MDCH to establish standards for the administrative costs of prepaid inpatient health plans (PIHPs), community mental health services programs (CMHSPs) and contracted organized provider systems.

In January 2006 MDCH Mental Health and Substance Abuse Administration established a Cost Allocation Work Group of MDCH staff, financial officers representing the PIHPs, consultants to the Michigan Association of Community Mental Health Boards (MACMHB), and Representative Bruce Caswell (See Attachment 1 for List of Members). The charge to the Work Group is to develop specific language and instructions for how administrative costs will be identified, allocated and reported so that all mental health entities are using one standard process. The expected outcomes of the project include reduction of variance in reported administrative costs across the state, identification of places where administrative functions can be made more efficient or consolidated, transparency of expenditures right down to the direct provider level, and ultimately a savings in administrative expenditures that can be used for direct services to consumers.

Status of Work

The Work Group met three times since it was established and prior to the writing of this report. The activities of the Work Group included:
1. Reviewing recent administrative analyses that were recently developed by MDCH and the Encounter Data Integrity Team (EDIT) which was utilized by the PIHPs and CMHSPs during the 2004 and 2005 fiscal years. EDIT is a joint MDCH- and MACMHB-sponsored committee made up of representatives of MDCH staff and PIHP financial officers and information technology coordinators that has been working toward standardization of encounter and cost data reporting since 2002. The document "Establishing Managed Care Administrative Costs," developed in 2003, was an EDIT-adaptation of work authored by Anthony Broskowski, Ph.D. of Pareto Solutions. (See Attachment 2 for the document). EDIT produced this document after reviewing reported PIHP administrative costs. While the state mean administrative rate (8.68%) was reasonable in relation to commercial managed care companies, EDIT found considerable variations across the 18 PIHPs. After investigation of possible factors (urban/rural, affiliation/standalone, contract service/direct-operated services) that may have contributed to the variations it was determined that a likely problem was that PIHPs and CMHSPs were differentially allocating costs to managed care administration and administration of services.

For fiscal year 2005, EDIT agreed that PIHPs should report on their administrative expenditures by each of seven "functions" as described in the "Establishing Managed Care Administrative Costs." Furthermore, if a PIHP delegated any function, or a portion thereof, to a CMHSP affiliate, substance abuse coordinating agency (CA) or provider network, the PIHP should report each of those entities' expenditures on the administrative functions. Format and instructions for this reporting were issued by MDCH in late 2005, and all18 PIHPs submitted reports at the end of January 2006. (See Attachment 3 for format and instructions).

2. In February the Cost Allocation Work Group conducted a preliminary analysis of the FY2005 PIHP administrative costs by the seven managed care functions revealed some shrinkage of the variation across the state, but still no distinct patterns due to configuration of the PIHP, delegation practices, or geographic location. (See Attachment 4) Since there are no Michigan benchmarks for what the managed care functions should cost (or what proportion of total expenditures they should comprise), neither the Work Group nor EDIT have yet drawn any conclusions about the data. It was clear that much more work needed to be done to discover the reasons for differences in the total administrative cost percentages as well as that of the individual administrative functions.

3. In March 2006 the Cost Allocation Work Group reviewed a description of a cost allocation model developed by Dr. Broskowski, and heard a presentation from Richard Visingardi, Executive Director of the Detroit-Wayne Community Mental Health Authority, about Dr. Broskowski's work.

Plan for Work in 2006

In addition to the above activities, the Cost Allocation Work Group also developed a four-phase work plan. The plan outlined below begins with identifying and applying an administrative cost allocation model to PIHPs and CMHSPs. A final phase will apply the administrative cost allocation model to providers.

Phase I: April 2006-June 2006
In the first phase of work, the Cost Allocation Work Group will continue exploring various cost modeling concepts prior to taking action. Dr. Broskowksi will meet with the Work Group on April 14th and present the cost model that he has developed and used with North Carolina and Lifeways in Jackson, Michigan, and is adapting for the Detroit-Wayne Community Mental Health Authority. Work Group members will have the opportunity to discuss with him how the model could be adapted for the various configurations of Michigan PIHPs (standalone PIHP, affiliation, directly-operated services and contract services).

Phase II: May 2006- July 2006
The important product of this phase will be a recommendation for an administrative cost allocation model to be used statewide. In preparation for that recommendation the Work Group will address policy questions that must be answered by MDCH. These policy questions include issues such as the size of the Medicaid or community populations served by public managers and to report and provide a distinction between the administrative functions provided by the PIHP and those provided by public providers. Another policy question is how the PIHP/hub should report and cost the Medicaid administrative functions it provides as an affiliate. In addition, the Work Group needs to address Mental Health Code responsibilities, and whether "firewalls" need to be established between CMHSPs and PIHPs, and between access systems and public providers.

Phase III: June 2006-August 2006
The third phase of the work will be to develop the standards, instructions, and training and technical assistance needs for the cost allocation model identified in Phase II. Training and technical assistance would occur during the FY'07.

Phase IV: October 2006-September 2007
PIHPs and CMHSPs will employ the agreed-upon cost allocation model during the FY'07 fiscal year. Outcomes of their work will be monitored using a modified Medicaid Utilization and Net Cost Report, the Administrative Cost Detail Report, and the Financial Status Report in July 2007 and January 2008.

MDCH will provide the Legislature periodic updates of the progress of the work.

Attachment 1

COST ALLOCATION WORK GROUP
2006 Roster

Pre-paid Inpatient Health Plans

Bruce Bridges	Northwest CMH Affiliation
Jeff Delay	Genesee County CMH Services
Michael Garrett	Detroit-Wayne County CMH
Dennis Grimski	Thumb Alliance PIHP
Jim House	CMH of Central Michigan
Eric Kurtz	CMH Partnership of Southeast Michigan
John North	Lakeshore Behavioral Health Alliance

Michigan Association of CMH Boards (MACMHB)

Susan Lawther	Consultant
Judith Taylor	Consultant

Michigan House of Representatives

Representative Bruce Caswell

Michigan Department of Community Health (MDCH)

Keith Andrykovich	Operations Administration
Patrick Barrie	Mental Health and Substance Abuse Administration
John Duvendeck	Mental Health and Substance Abuse Administration
John Jokisch	Mental Health and Substance Abuse Administration
Irene Kazieczko	Mental Health and Substance Abuse Administration
Jill Kemp	Mental Health and Substance Abuse Administration
Teresa Simon	Operations Administration
Karen Spak	Operations Administration
Gary VanNorman	Operations Administration
Judy Webb	Mental Health and Substance Abuse Administration
Debra Ziegler	Mental Health and Substance Abuse Administration

Attachment 2

Michigan Specialty Supports and Services
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

ESTABLISHING MANAGED CARE ADMINISTRATIVE COSTS

Revised June 20, 2005

Michigan Department of Community Health
Mental Health and Substance Abuse Services Administration

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I. Overview:

The Centers for Medicare and Medicaid Services (CMS) promulgated rules for the 1997 Balanced Budget Act that specifies requirements for the management of the federal Medicaid Program. These include explicit requirements regarding the process for determining capitation rates for a Managed Care program. These requirements are contained in the Code of Federal Regulations (CFRs).

Among the requirements are guidelines for separating administrative and service costs. In the process of setting capitation rates, these costs are evaluated separately and in Michigan, are then combined to create a single capitated rate for the Prepaid Inpatient Health Plan (PIHP).

For simplicity, the MDCH will use the same process for separating administrative and service costs in the Indigent ("General Fund") program. This will create a single uniform method for identifying costs throughout the public mental health system.

In order to establish the costs of providing treatment, supports and services, each PIHP network must submit financial information related to each service encounter delivered regardless of funding source in the form of an "aggregate net cost per unit." This aggregate net cost per unit is calculated by the PIHP by dividing the sum of the Medicaid costs in the PIHP's service area (including affiliates) for a procedure by the total units of the procedure delivered to Medicaid beneficiaries in the PIHP's service area (including the affiliates). This provides a single uniform system for identifying the costs of Medicaid treatment, supports and services. The total Medicaid expenditures and total units are reported on the PIHP's Medicaid Utilization and Net Cost Report at six and twelve months. The total CMHSP expenditures and total units are reported on the CMHSP total Sub-element Cost Report at twelve months. It is no longer required that a cost per unit be reported with the encounter data.

The second part of the data submission - administrative and other indirect costs attributable to managed care - are not to be reported in the encounter data. Instead, administrative costs are reported using the PIHP Medicaid Utilization and Net Cost Report and the CMHSP Total Sub-element Cost Report in accordance with guidelines that follow. Two reports of administration are submitted. One report covers Medicaid Administration only and is submitted by the PIHP. This report accumulates all Medicaid Managed Care Administration costs throughout the PIHP's structure. The second report is submitted by each CMHSP and incorporates all managed care administration for all fund sources for that CMHSP.

In the final development of Medicaid capitation rates, the funding for the administrative costs attributable to managed care will be added to the service rate to create a total capitation rate for each PIHP.

This paper presents guidelines for PIHPs and CMHSPs in identifying Managed Care administrative costs. These guidelines differ substantially from prior instructions

regarding Board Administration. The changes are made to allow for compliance with Federal requirements, and establish a single system for reporting administration.

II. Principles

The following principles guide PIHP and CMHSP efforts to identify Managed Care Administration costs:

1. **System Consistency:** The system is best served if CMHSPs follow, in good faith, common definitions for both services and management functions. At the same time, local differences in both service provision and management will result in different interpretation of guidance, at least in the short run. Reasonable variation will be tolerated. DCH anticipates that the costs per unit and the amount identified for PIHP Administrative functions will vary across the state but that over time this variation will be reduced. Managed Care Administration reported by CMHSPs may have greater variability because of regional differences in the delegation of Medicaid functions. The CMHSP cost report will provide several lines for reporting Managed Care Administration to help identify and explain this variation.

2. **Aggregate Net Cost Per Unit:** This amount for each procedure code will be based upon actual costs of Medicaid services within a PIHP area, adjusted for considerations of market rates or projections of unavoidable cost increases. This net cost per unit **includes** the indirect, overhead and management costs of delivering the service. However, it **excludes** the costs of managing the functions identified in #3 below.

3. **Managed Care Administrative Functions.** Managed care functions are categorized, for purposes of this document, into seven groups, as follows:

    A. Utilization Management
        1. Access and Eligibility Determination
        2. Level of Care Assessment/Service Support Selection
        3. Authorization
        4. Utilization Review
        5. Care Management
    B. Customer Services
        1. Information Services
        2. Coordination of Customer participation in Managed Care Activities
        3. Complaint, Grievance and Appeals Processes
        4. Community Benefit
    C. Provider Network Management
        1. Network Development
        2. Contract Management
        3. Network Policy Development

4. Credentialing and Privileging

D. Quality Management
   1. Standards Setting
   2. Performance Assessment
   3. Regulatory Management/Corporate Compliance
   4. Managing Review Processes
   5. Quality Process Facilitation
   6. Research
   7. Provider Education and Training

E. Financial Management
   1. Financial Operations and Risk Management
   2. Claims Management

F. Information Systems Management
   1. DCH Contract Management Support
   2. Reporting

G. General Management

Although this categorization is commonly used it is not intended that it describe the actual or ideal organizational structure of any PIHP or CMHSP. Nor is it intended to suggest that the identified sub-categories should be clustered organizationally according to this configuration.

4. **Medicaid Reporting and Models of PIHP-Provider Relationship:**
There is great variation in the nature of the relationship between the PIHP, CMHSPs and service providers. Before identifying Managed Care Administrative costs, the location of each management function listed above must be identified. In many arrangements, portions of some or all management functions are carried out by more than one administrative structure. It is important that the costs associated with all components of the function be identified, regardless of where they are carried out. Specifically, service delivery entities may carry out Managed Care Administrative functions, the cost of which should not be included as a service delivery cost (i.e., they should not be included as part of the 'allowable amount'). On the other hand, some service delivery agencies carry out management functions which are identical in nature to Managed Care Administrative functions as described in this document, but which should be included as service delivery costs. This paper identifies three circumstances under which such functions of service delivery entities should be included as Managed Care Administrative functions:

- **Delegation of Responsibility** – PIHPs that have affiliated CMHSPs and Substance Abuse Coordinating Agencies (CAs) acting in the capacity of CSSNs, are required to include in their service and funding agreements a description of the PIHP Administrative functions that have been delegated to the CSSN (42CFR230). PIHPs may also delegate Administrative functions to non-CSSN contracted Provider entities through a contractual arrangement. The cost of all Managed care Administrative functions delegated by the PIHP to a Provider entity, including a CSSN, must be

added to the costs incurred directly by the PIHP to form the total Managed Care Administrative cost reported by the PIHP.

- **Functions in the Interest of the PIHP** – All service delivery entities carry out some functions which are identical in nature to those described above as Managed Care functions. For example, all Health Care providers and management agencies are required to perform regulatory management functions; most service providers engage in customer service and utilization review activities, etc. When delegation of responsibility is not explicit, service provider entities in cooperation with the PIHP should identify as Managed Care Administrative functions, with associated costs, those activities which they carry out in the interest of the PIHP.
- **Shared Risk Arrangements** – sub-capitated entities may perform many Managed Care Administrative functions which are carried out in both their interest and the interest of the PIHP. When there is no explicit delegation of responsibility by the PIHP, the sub-capitated entity and PIHP cooperatively allocate functions serving both interests; the costs, therefore, are allocated similarly.

5. **Level of Cost Detail for Medicaid Reporting** -- The PIHP Administrative rate component of the total Medicaid capitation rate will be based on the total cost of carrying out PIHP Administrative functions. The PIHP is expected to identify and establish a total cost for those functions carried out directly by the PIHP and to identify and establish total costs for functions carried out by service entities to which functions are delegated. Responsibility for and costs must be identified for those entities with which the PIHP has established a direct delegation relationship. Such entities should identify total costs for functions for which they have assumed responsibility regardless of whether they carry out the function directly or sub-delegate it.

6. **Isolating Medicaid Costs** – For purposes of establishing the Medicaid capitation rate, only PIHP Administrative costs related to services chargeable to Medicaid revenue will be utilized. For this purpose, when the PIHP functions are related to services in addition to Medicaid services, the PIHP should allocate the total cost of carrying out a function as a proportion of Medicaid expenditures to total expenditures or via another standard cost allocation method.

7. **Indigent Fund and Models of PIHP Provider Relationship**
   Some CMHSPs are purchasing managed care administrative functions for the indigent population from a related PIHP. For these arrangements, the PIHP should treat the contract with the CMHSP as an earned revenue, and not include those costs in its Indigent Fund administrative costs. The CMHSP that pays for the administrative services would include such costs as part of its Indigent Fund cost report.

Where a CMHSP has delegated administrative functions to a CSSN or other provider entity, these costs should be incorporated into the CMHSP administrative cost reporting. Similarly, CSSN administrative activities undertaken on behalf of the CMHSP should be reported as managed care administration. If CSSNs perform functions in both their own interests and the interests of the CMHSP, these costs would be included as managed care administration only if there is a specific delegation from the CMHSP.

8. **Cost Principles** -- In calculating both the aggregate net cost per unit (adjusted for market-related and other factors) and the Managed Care Administrative cost, the PIHPs and CMHSPs will use cost guidelines, including A-87 costing principles, as included in the relevant MDCH contract.

III. Managed Care Administrative Functions

The following core functions have been identified as managed care administration. The costs of these functions must be reported by PIHPs and CMHSPs, regardless of who carries them out. The terminology used below may not correspond with that used in individual PIHPs and CMHSPs; further, some entities may consider components or sub-components listed within these categories to belong elsewhere. Since creation of the Administrative component of the rate will not require reporting by category or component of each function, this is okay.

Since both CMHSPs and PIHPs use these guidelines for both Medicaid and Indigent Fund reports, the term Managed Care Entity is used in this paper to refer to the organizations holding the Medicaid and Indigent Funds contract, ie the PIHPs and CMHSPs.

A. UTILIZATION MANAGEMENT

Utilization Management (UM) is a set of administrative functions that pertain to the assurance of appropriate clinical service delivery. Through the application of written policies and procedures, Utilization Management is designed to ensure (1) that only eligible beneficiaries receive specialty plan benefits; (2) that all eligible beneficiaries receive all medically necessary specialty plan benefits required to meet their needs and desires; and (3) that beneficiaries are linked to other Medicaid, Health Plan or other services when necessary.

The list of functional components below should be used as a guide as the Managed Care Entity locates this function and identifies the costs associated with it. Functional components may be performed by a managing entity, or delegated to an entity within the Managed Care structure. Further, functional components are likely to be distributed among several organizational components. Some components may not be carried out in some entities. Functional components that are carried out as part of a billable service encounter should not be included as a Managed Care Administrative function. Because UM is also a key function of an effective service provider, UM activities, carried out as a part of a provider's self-monitoring process (i.e., when carried out in the interest of the

provider), should not be included in the cost of managed care functions, as indicated in Principle #4 above.

Components of utilization management include:

- **Access and Eligibility Determination.** This functional component includes both clinical and financial eligibility determination. Specifically, this includes:
  - development of access and eligibility policy and procedures,
  - initial contact with potential consumers,
  - collection of consumer specific information
  - services referral, including both inpatient and alternative emergency services and non-emergency initial referral
  - initial screening/first appointment,
  - verification of funding sources including determination Public Funding status and first and third part liability,
  - documentation and monitoring of activities.
- **Level of Care Assessment/ Service and Support Selection.** This component is the initial and ongoing interface between the consumer--clinical treatment and support team and the Managed Care Organization. This includes:
  - Determination of Medical Necessity,
  - Assessment of risk
  - Application of Service Intensity criteria
  - Continuing Stay review
  - Specialist review
  - Development of financial and clinical eligibility criteria, Level of Care criteria, Service Selection Guidelines, and Best practice Guidelines as well as procedures for applying them
  - Documentation and monitoring of activities
- **Authorization.** This component is the process of linking LOC and Service Selection processes to payment processes. It includes
  - Notification of authorization, or denial of request, to the consumer and provider
  - Documentation of decision in IS linking to claims processing
  - Development of authorization policy and procedure
  - Documentation and monitoring of activities
- **Utilization Review.** This component provides review/monitoring of individual consumer records, specific provider practices and system trends. Review of activities of both the managing entity and the provider network are included. It includes review and monitoring to determine appropriate application of Guidelines and Criteria in the following areas:
  - LOC determination
  - Application of Service Selection Criteria
  - Application of Best Practice Guidelines
  - Consumer outcomes

- Over-Utilization/under Utilization
- Review of Outliers
- Development of review criteria and processes for individual consumer records
- Development of procedures for system level data review
- Policy and procedures regarding use of review documents
- Documentation and monitoring of component activities

- **Care Management.** This component recognizes that some consumers represent such service or financial risk to the organization that closer monitoring of the individual case is warranted. Responsibilities include:
  - Development of selection criteria for consumers for care management. E.g., out of area consumers, inpatients, etc.
  - Policy and procedure detailing role of the managing entity and provider
  - Documentation and monitoring of component activities

B. CUSTOMER SERVICES

The Customer Services function encompasses activities directed at the entire population of the Board's service area, including non-treatment/support services to consumers. Although most CMHSPs have a dedicated Customer Services Division/Department, customer services functions are frequently implemented outside this dedicated unit. Virtually all service providers provide customer services functions, as a part of the service delivery process, which should not be included in the cost of managed care administrative functions. The test of whether the function is performed in the interest of the provider or Managed Care Entity (Principle # 4 on page 4 above) should be applied.

The Recipient Rights function is to be included as a managed care administrative function and its costs attributed to both Medicaid (PIHP) and Indigent (CMHSP) administration. Recipient Rights functions are mandated by the State Mental Health Code and had previously been excluded from these guidelines for PIHP administration. However, these functions are also mandated in the PIHP contracts and are performed on behalf of Medicaid recipients. In some situations they fulfill the responsibilities for handling grievances and appeals required under Federal law. Therefore they are now to be included as Managed Care administration.

The following list of components will assist in locating functions which may be carried out within a central organization or delegated directly to a service provider entity. Both the list and the labeling of components is intended to be assistive. Managed Care Entities may not carry out some functions, may label them differently, or may delegate them elsewhere.

- **Information Services.** This component includes activities directed to the general population of the service area as well as to consumers of treatment and support services. These include
  - General orientation of new and potential consumers to the benefits available from the organization, as well as methods of accessing services. Potential consumers include the community at large.

- Development and dissemination of informational brochures; coordinating community and stakeholder input and disseminating of specialized information about benefit plans, service providers and treatment and support practices. This includes development of culturally sensitive and/or alternative communication systems.
- Operation of a telephone line and web site(s) in order to provide information about benefit plans and to respond to general inquiries.
- Outreach activities to identify and establish communication with under-served groups.
- Marketing and Public Relations activities

- **Coordination of Customer Participation in Managed Care Activities.** This component includes
  - Development of policy and a program of activities designed to engage consumers, and other stakeholders, including members of the general public, in decision oriented activities throughout the organization, including its provider network.
  - Coordination of selection processes
  - Training and orientation of customers, including consumers, to participate actively in Advisory Groups, task forces, working committees and other management related groups.
- **Customer Complaint, Grievance and Appeals Processes.** Both formal and informal grievance and appeal mechanisms are coordinated as part of the Customer Services function. This includes
  - Process to collect, store and analyze reports from consumers and other persons regarding problems in the delivery system
  - Investigation and management of informal complaints
  - Investigation and management of all formal grievances and appeals
  - Operation of the CMHSP Recipient Rights Office.
  - Administrative Fair Hearings conducted by MDCH.
  - Formal tracking and coordination of Complaint Management processes, across the entire network.
  - Informal means used by the Managed Care Entity to resolve complaints from consumers about providers
- **Community Benefit.** This component consists of activities directed at the population of the entire service area, or sub-groups of that population, rather than at identified individuals. It focuses on activities designed to promote wellness and Healthy Communities, such as
  - Provision of specialized educational and informational services to at-risk groups
  - Community emergency and group trauma services
  - Partnership arrangements with community organizations to provide a specialty health service perspective on issues of concern to the general population or sub-groups served by the organization
  - Outreach activities and screening of the general population, or identified sub-groups, for health conditions such as depression, eating disorders, etc.

- Cross training of, and specialized consultation with school, jail, police, fire, church and other service personnel
- Participation in community planning bodies, including the Human Services Coordinating Council, Indian Health Centers and other groups.

C. Provider Network Management

The Provider Network Management function encompasses activities directed at ensuring that qualified providers in sufficient number and variety are available to permit meaningful consumer choice and that the provider network is in compliance with regulatory requirements and the performance expectations of the Managed Care Entity. Providers include both organizations and individual professional practitioners providing clinical services or paraprofessionals providing supports to consumers. Although most providers are part of the Provider Panel, network management activities frequently include off-panel provider management as well. All organizations and practitioners providing specialty supports and services to consumers are considered part of the network. Utilizing Principle #4 on page 4 above, PIHP network management functions carried out by a CSSN or other Service Provider vis-à-vis its sub-contractors or practitioners is a Managed Care Administrative function if such activities are performed in the interest of the Managed Care Entity. PIHPs which are CMHSPs that operate services directly must include such a service provider function as if it were a contracted provider regardless of whether a contract actually exists.

Provider Network Management consists of the following components:

- **Network Development** -- This is the process of identifying member service needs and procuring sufficient providers to meet those needs. Activities include:

  - Needs Assessment, including analysis of the demographic characteristics of the community, the customers and the current and past consumer population. Needs assessment should include analysis of the historic patterns of services and projection of demand for services
  - Analysis of current network capacity to meet projected need and development of a "gap assessment" which identifies procurement needs.
  - Development of an annual network plan.
  - Procurement of providers using a process which meets Federal and State standards and addresses identified program needs and required/desirable provider characteristics.
  - Development of agreements with alternative payors or related agencies with a goal of coordinating care (such as with DHS, MRS and Schools)
  - Recruitment of specialized supports such as staff or contracted interpreters, translators and bi-lingual/bi-cultural clinicians
  - Training for network providers concerning performance expectations.

- **Contract Management** consists of the following activities:

- Development of provider contract language including boilerplate language, payment models, performance expectations, operating expectations, dispute resolution processes, sanctions, incentives, etc.
- Negotiation of contracts
- Monitoring Providers for compliance with all aspects of the contract.
- Conducting reviews for evidence of abuse and/or fraud.
- Sanctioning providers, through Plans of Compliance or other means
- Managing the comprehensive review process as part of contract renewal.
- Managing contracts for consumer services with non –panel providers

- **Network Policy Development** -- This includes development of standards for participation in the provider panel. For Managed Care Entity whose service delivery system operates through affiliated CSSNs or other service providers, standards for sub-contracting are included in this area. Operating and performance expectations are also included through this Policy Development function.

- **Credentialing, Privileging and Primary Source Verification:** These functions are part of network management although frequently carried out by staff participating in QM functions. These functions are carried out at both service delivery and Administrative levels. The Managed Care Entity must, at least, verify the credentialing done at the service delivery level. Further, the Managed Care Entity must perform these function vis-à-vis Utilization Management and other management staff.

  - **Credentialing** is the process of validating the qualifications of a licensed practitioner or facility to provide services in a health care network or its components.
  - **Primary Source Verification** is the process of independently contacting the organization responsible for issuing a credentialing requirement to verify the report of a practitioner or facility.
  - **Privileging** is the process of reviewing specific education, training, and experience to determine the consumer populations and/or service modalities the practitioner or facility will be approved to provide.

D. Quality Management

The Quality Management function encompasses activities directed at ensuring that standards of staff, program and management performance exist, that compliance with them is assessed and that ongoing improvements are introduced and assessed.

CMS regulations require the PIHP to develop an overall Quality Assessment and Performance Improvement Program (QAPIP) for its organization and its provider network. Specifications for the QAPIP are detailed both in the CFRs and the MDCH Contract. The QAPIP includes the development of an annual QI Plan that includes those

specific developmental and improvement activities to improve the overall effectiveness of the PIHP network's clinical and administrative practices.

Virtually all service provider organizations have Quality Management programs. Some components of these organizations are mandated for all providers (such as regulatory management or corporate compliance); others are maintained in the interest of the provider. Unless specifically delegated by the Managed Care Entity or manifestly operated in its interests, these activities of provider organizations should not be identified as Managed Care Administrative functions or included in the costing process.

Components of Quality Management include:

- **Standard Setting.** This component includes review, analysis and recommendations concerning standards, and measurement methodologies in the following areas essential to a continuous quality improvement orientation
  - Choice of accrediting body
  - Research based Best Practice Guidelines, including analysis of create vs. purchase options, management of a stakeholder input process and training of providers and Utilization Management staff
  - Clinical pathway protocols and other authorization criteria
  - Credentialing standards and procedures
  - Establishing methods to establish eligibility for services, such as selecting standard assessments, diagnostic tests, medical necessity criteria, ASAM criteria etc.
  - Performance expectations for both clinical and management programs
- **Conducting Performance Assessments.** This component includes both routine, periodic performance assessment and specially designed evaluation activities. Performance assessments and evaluations, as used here, are generally analyses of data submitted as part of regular management information requirements or as part of a special study. The results of both periodic and special performance assessments are provided to the PIHP's leadership team on a regular basis as part of the management decision-making process. Results of selected periodic assessments are made available to consumers and the community.
- **Regulatory Management/Corporate Compliance.** This component includes review of financial and clinical source documents and summary data conducted, or overseen, by Managed Care Entity staff for compliance with regulations of outside bodies, including the State of Michigan, CMS and other federal regulatory bodies. Activities include:
  - Developing a compliance plan that focuses on regulations dealing with healthcare fraud and abuse.
  - Maintaining current inventory of regulations and conducting prevention activities.
  - Providing direction to contractors regarding their responsibilities
  - Ensuring that compliance issues are adequately addressed in vendor contracts

    - Establishing a compliance friendly environment
    - Taking action when non-compliance issues are revealed.
- **Managing Outside Agency Review processes.** This component includes ensuring that source material is complete and available for reviews by outside bodies, including
    - Accrediting bodies
    - DCH Certification reviews and financial audits
    - Licensing bodies
    - Non-DCH payer audits and reviews (CMS, Auditor General, OIG, etc.)
- **Research.** Research activities, including management of a Research Committee.
- **Quality Process Facilitation.** This component consists of activities aimed at continuous improvement of the processes by which agency and contractor business is conducted. It includes facilitation of activities related to management processes and TA/facilitation of activities in contract agencies.
- **Provider Education and Training and Quality Management Oversight.** This component includes activities related to ensuring that contractors have and carryout their own quality management plan, as well as ensuring that a Quality Improvement Culture is developed and maintained within all clinical and management arenas. Thus, activities include routine, periodic education and training activities and education/training activities designed to address special issues revealed by performance assessments, audits, compliance reviews or other means. Training of service delivery staff to meet program requirements is not a Managed Care Administrative function (examples include Group Home Training, PCP training, etc.).
- **Development of an Annual Quality Improvement Plan.** This Plan establishes specific goals for the coming year, consistent with the Managed Care Entity Strategic Plan and identifies monitoring mechanisms and timeframes with respect to their achievement.

E. Financial Management

Financial Management consists of the processes for managing revenues and expenditures in order to provide accountability to management and funders, maximize financial resources and maintain fiscal integrity. Because financial management is also a key function of an effective service provider, financial management activities, carried out as a part of a provider's internal management process (i.e., when carried out in the interest of the provider), should not be included as a Managed Care Administration cost. The test included in Principle #4 on Page 5 above should be applied.

Critical components of financial management include:

- Budgeting, General Accounting (AR, AP, etc.), and Financial Reporting
- Service unit and Client-centered Cost analyses and Rate-setting may be done as a Managed Care Administrative function. Alternatively, the Managed Care

Entity may set standards for rates, which are then developed as a service delivery function.

- Risk Analysis, Risk Modeling, and Underwriting
- Insurance and re-insurance, management of risk-pools
- Purchasing, Administrative Contracts, and Inventory Management
- Supervision of audit and financial consulting relationships
- Claims adjudication and payment

Consistent with Principle #4 above, the following functions may be directly identified and allocated as a Managed Care administrative function costs:

- Managing typical general accounting processes of the Managed Care Entity.
- Processing bills from external provider agencies, payments, reconciliation, appeals and all other functions related to payments to external service providers
- Receiving and reconciling managed care contract revenues
- Budget and financial analysis and reporting related to managing within capitated, sub-capitated or other risk-based funds
- Managing unspent funds within the risk corridor for alternative services
- Planning to contain risk, including actuarial analysis

The following costs are to be considered Service Management Costs, and should not be factored into the health plan *administrative costs*, but included in the allowable amounts rate development:

- Billing and collecting third party payors
- For fee for service Medicaid hub and spoke arrangements, billing the PIHP
- Ability to pay determinations
- On-site eligibility verification
- Obtaining and recording local matching contributions

Remaining financial management costs which cannot be directly allocated must be separated using an indirect cost allocation method.

F. Information Systems Management

Information Systems Management includes processes designed to support management, administrative and clinical decisions with the provision of data and information and to support the accountability and information requirements of funders, regulatory bodies, consumers and communities. Components include hardware, software, specific applications and their integration, network configuration and connectivity. Telecommunications equipment, software, and management are often included. Information Technology (IT) refers to the hardware and connectivity—including individual workstations, laptops, phone systems, mobile personal assistants (such as Palm Pilots), servers, routers, and management of both Local and Wide Area Networks (LANs and WANs). Managing security requirements for access to the network is also included in IT.

Information Systems within the behavioral healthcare system usually fall into two (2) categories: Managed Care and Practice Management. **Managed Care** Information System Management functions are those which support all other Managed Care Administrative functions.

Practice Management Information System Management functions which allow providers to deliver clinical services and manage the interests of the provider agency. Related Practice Management costs to be borne by the provider include all IS Practice Management software, and related hardware, telecommunication and staffing costs pertaining to provider service delivery, and the submission of claims and data into the payor or fund source. These costs are not Managed Care Administrative costs.

In this context, include the portions of the following IS systems that are not related to practice management functions as managed care administrative costs:

- hardware, software and other devices for collection, storage, retrieval and reporting of demographic, service encounter, sub-element cost and performance indicators
- the system for authorizing services to provider agencies
- the system of enrolling both network organizations and professionals into the managed care software for credentialing and claims payment purposes.
- the system for managing and processing claims for services across the provider network
- the system for processing payment to service providers and its effectiveness
- systems to collect, analyze and act on data regarding the quality of services
- confidentiality and security sub-systems intended to protect integrity of data
- capacity to collect, verify, store and analyze eligibility information
- system for exchanging eligibility information between the managed care entity, affiliates and providers
- collecting information necessary to demonstrate compliance with the contract or with performance standards, such as establishing service penetration rates
- MDCH/Management Reporting including the costs of reporting demographic, encounter, cost and performance indicator to MDCH by the PIHP. Administrative costs in performing reporting requirements may also include the costs associated with data validation and correction.

Information Management functions can be either Managed Care or Provider Administration, depending on which entity's interests are served. The following are examples of items which are not Managed Care Administrative functions:

- hardware, software and personnel for collection, storage, retrieval and submission to payors of demographic, service encounter, sub-element cost and performance indicators
- systems to collect, analyze and act on data regarding the quality of services, when this information is used by the provider to strengthen its own capability

Administrative costs in performing reporting requirements may also include the costs associated with data validation and correction.

Information Management functions can be either Managed Care or Provider Administration, depending on which entity's interests are served. The following are examples of items which are not Managed Care Administrative functions:

- hardware, software and personnel for collection, storage, retrieval and submission to payors of demographic, service encounter, sub-element cost and performance indicators
- systems to collect, analyze and act on data regarding the quality of services, when this information is used by the provider to strengthen its own capability
- confidentiality and security sub-systems intended to protect integrity of the provider's data
- capacity to connect to the Managed Care Entity's eligibility system
- ability to bill for services
- internal management reports the provider may create for its payer reports or own internal operations.
-

G. General Management

General Management consists of functions which do not fit elsewhere. Many of these are Executive or Leadership functions, including:

- The CEO of the managed care organization (PIHP). The CEO of the Managed Care Entity may also be the CEO of a Provider entity, in which case costs must be allocated between the two functions.
- The Chief Operating Officer (COO), or equivalent staff position reporting to the CEO. The COO may be dedicated to the Managed Care Entity or have divided responsibility to management of the provision of service.
- The Managed Care Entity's Medical Director. The Medical Director provides overall leadership to such functions as: Clinical Policies/Protocols; Development of Treatment Guidelines and Level of Care Criteria; Access, Eligibility, Triage and Authorization Line protocols; and the Utilization Management and Utilization Review processes.
- Oversight of delegated functions is considered a Managed Care Administrative function.

Other general management activities include:

- Activities to organize an affiliation governance structure
- Activities to organize an affiliation's management structure, including meetings of the PIHP with its CMHSPs, CA, or network providers.
- Activities to organize and maintain any management sub-workgroup structures, where the Managed Care Entity is providing lead staff direction/assistance.
- Administrative support.
- Legal support

- Management and technical consultants provided assistance to the Managed Care Entity.
- Other associative and staffing costs in managing a specialty health plan and a regional provider network.

Attachment 3

INSTRUCTIONS FOR PIHP MEDICAID ADMINISTRATIVE COST REPORT

There are six worksheets in this template. Below are instructions for each sheet.
Submit the completed template via E-mail to Kathy Haines by 5 p.m. January 31st: haineskat@michigan.gov.
Questions may be directed to her at that address or by telephone at (517) 335-0179

PIHP TOTAL WORKSHEET
This worksheet is the sum of all Medicaid Administrative expenditures for administrative activites performed for
Medicaid mental health, developmental disabilities, and substance abuse programs
The expenditures must include those functions performed by the PIHP as well as any functions that were
partially or fully delegated to affiliates, substance abuse coordinating agencies (CAs) and providers
The detail of expenditures delegated to affiliates, CAs, and providers must be provided in the subsequent worksheets
Line 23 and 24: enter the gross Medicaid expenditures (service plus admin), and the sum of the Medicaid administrative expenditures

Calculation: enter the percent of total expenditures that administrative activity expenditures represents

PIHP MHDD WORKSHEET
This worksheet is the sum of all Medicaid Administrative expenditures for administrative activites performed for
Medicaid mental health and developmental disabilities programs
The expenditures must include those functions performed by the PIHP for the mental health and developmental disabilities benefits
as well as any functions that were partially or fully delegated to affiliates and providers for the MH/DD benefits
Line 23 and 24: enter the gross Medicaid expenditures (service plus admin) FOR MH/DD ONLY, and the sum of the Medicaid administrative expenditures for MH/DD
Calculation: enter the percent of total MH/DD expenditures that administrative MH/DD activity expenditures represents

PIHP SA
This worksheet is the sum of all Medicaid Administrative expenditures for administrative activites performed for
Medicaid substance abuse programs
The expenditures must include those functions performed by the PIHP for the substance abuse benefits
as well as any functions that were partially or fully delegated to substance abuse coordinating agencies for the SA benefits
Line 23 and 24: enter the gross Medicaid expenditures (service plus admin) FOR SA ONLY, and the sum of the Medicaid administrative expenditures for SA
Calculation: enter the percent of total SA expenditures that administrative SA activity expenditures represents

AFFILIATE
This worksheet should include only those Medicaid administrative functions that were delegated from the PIHP

A separate column should be used for each affiliate. Please enter the name of the affiliate at the top.
Line 23 and 24: enter the gross Medicaid expenditures (service plus admin) FOR MH/DD FOR THAT AFFILIATE ONLY, and the sum of its Medicaid expenditures for administrative functions for MH/DD
Calculation: enter the percent of total MH/DD expenditures that administrative MH/DD activity expenditures represents

CA
This worksheet should include only those Medicaid administrative functions that were delegated from the PIHP.
A separate column should be used for each substance abuse coordinating agency. Please enter the name of the CA at the top
Line 23 and 24: enter the gross Medicaid expenditures (service plus admin) FOR THAT CA ONLY, and the sum of its Medicaid expenditures for the SA administrative functions that were delegated by
Calculation: enter the percent of total SA expenditures that administrative SA activity expenditures represents

PROVIDER
This worksheet should include only those Medicaid administrative functions that were delegated directly from the PIHP.

A separate column should be used for each provider. Please enter the name of the provider at the top.
Line 23 and 24: enter the gross Medicaid expenditures (service plus admin) FOR MH/DD FOR THAT PROVIDER ONLY, and the sum of its Medicaid expenditures for MH/DD administrative functions that
Calculation: enter the percent of total MH/DD expenditures that administrative MH/DD function expenditures represents

PIHP ADMINISTRATIVE COSTS

PIHP Name:

Data

PIHP Gross Medicaid Expenditures FY04-05:	
PIHP Medicaid Mental Health Expenditures FY04-05:	
PIHP Medicaid Substance Abuse ExpendituresFY04-05	$0

PIHP Administrative Functional Areas:	Direct/Centralized Costs	Delegated Costs*	Total Costs
Customer Services			
Financial Management			
General Management			
Information Systems Management			
Provider Network Management			
Quality Management			
Utilization Management			
TOTAL PIHP Admin Costs	$0.00	$0.00	$0

Calculation

Gross Medicaid Expenditures FY04-05	
Medicaid Administration Expenditures FY04-05	
PIHP Administration as Percent of Medicaid Expenditures:	

*Delegated costs are the sum of the delegated administrative costs from Affiliate(s), CAs and Providers on next worksheets

PIHP ADMINISTRATIVE COSTS

PIHP Name:

Data
PIHP Gross Medicaid Expenditures FY04-05:
PIHP Medicaid Mental Health Expenditures FY04-05:
PIHP Medicaid Substance Abuse ExpendituresFY04-05

PIHP Administrative Functional Areas:	Direct/Centralized Costs	Delegated Costs*
Customer Services		
Financial Management		
General Management		
Information Systems Management		
Provider Network Management		
Quality Management		
Utilization Management		
TOTAL PIHP Admin Costs	$0.00	$0.00

Calculation
Gross Medicaid Expenditures FY04-05
Medicaid Administration Expenditures FY04-05
PIHP Administration as Percent of Medicaid Expenditures:

*Delegated costs are the sum of the delegated administrative costs from Affiliate(s) and Providers on next worksheets
Do not include substance abuse administrative costs here.

PIHP ADMINISTRATIVE COSTS

PIHP Name:

Data
PIHP Gross Medicaid Expenditures FY04-05:
PIHP Medicaid Mental Health Expenditures FY04-05:
PIHP Medicaid Substance Abuse ExpendituresFY04-05

PIHP Administrative Functional Areas:	Direct/Centralized Costs	Delegated Costs*
Customer Services		
Financial Management		
General Management		
Information Systems Management		
Provider Network Management		
Quality Management		
Utilization Management		
TOTAL PIHP Admin Costs	$0.00	$0.00

Calculation
Gross Medicaid Expenditures FY04-05
Medicaid Administration Expenditures FY04-05
PIHP Administration as Percent of Medicaid Expenditures:

*Delegated costs are the sum of the delegated administrative costs from CAs on the CA worksheets
Do not include MH/DD administrative costs here

PIHP ADMINISTRATIVE COSTS DELEGATED

Affiliate(s) Name(s):					
Medicaid Administrative Functional Areas:	Delegated Costs	Delegated Costs	Delegated Costs	Delegated Costs	Delegated Costs
Customer Services					
Financial Management					
General Management					
Information Systems Management					
Provider Network Management					
Quality Management					
Utilization Management					
TOTAL Medicaid Admin Costs					

Calculation
Mental Health Medicaid Expenditures FY04-05
Mental Health Medicaid Administration FY04-05
MH Administration as Percent of Medicaid Expenditures:

PIHP ADMINISTRATIVE COSTS DELEGATED

CA(s) Name(s):				
Medicaid Administrative Functional Areas:	Delegated Costs	Delegated Costs	Delegated Costs	Delegated Costs
Customer Services				
Financial Management				
General Management				
Information Systems Management				
Provider Network Management				
Quality Management				
Utilization Management				
TOTAL Admin Costs				

Calculation
Substance Abuse Medicaid Expenditures FY04-05
Substance Abuse Medicaid Administration FY04-05
SA Administration as Percent of Medicaid Expenditures:

PIHP ADMINISTRATIVE COSTS DELEGATED

Provider* Name(s):				
Medicaid Administrative Functional Areas:	Delegated Costs	Delegated Costs	Delegated Costs	Delegated Costs
Customer Services				
Financial Management				
General Management				
Information Systems Management				
Provider Network Management				
Quality Management				
Utilization Management				
TOTAL Admin Costs				

Calculation
Provider Medicaid Expenditures FY04-05
Provider Medicaid Administration FY04-05
Provider Administration as Percent of Medicaid Expenditures:

*Report provider administrative expenditures only when the PIHP delegates administrative functions through direct contract with provider

Attachment 4

Percent of Medicaid Expenditures Spent on Medicaid Administration by PIHP
Includes Costs Delegated to the Providers, Coordinating Agencies (CA), and Affiliate CMHSPs
FY 2005

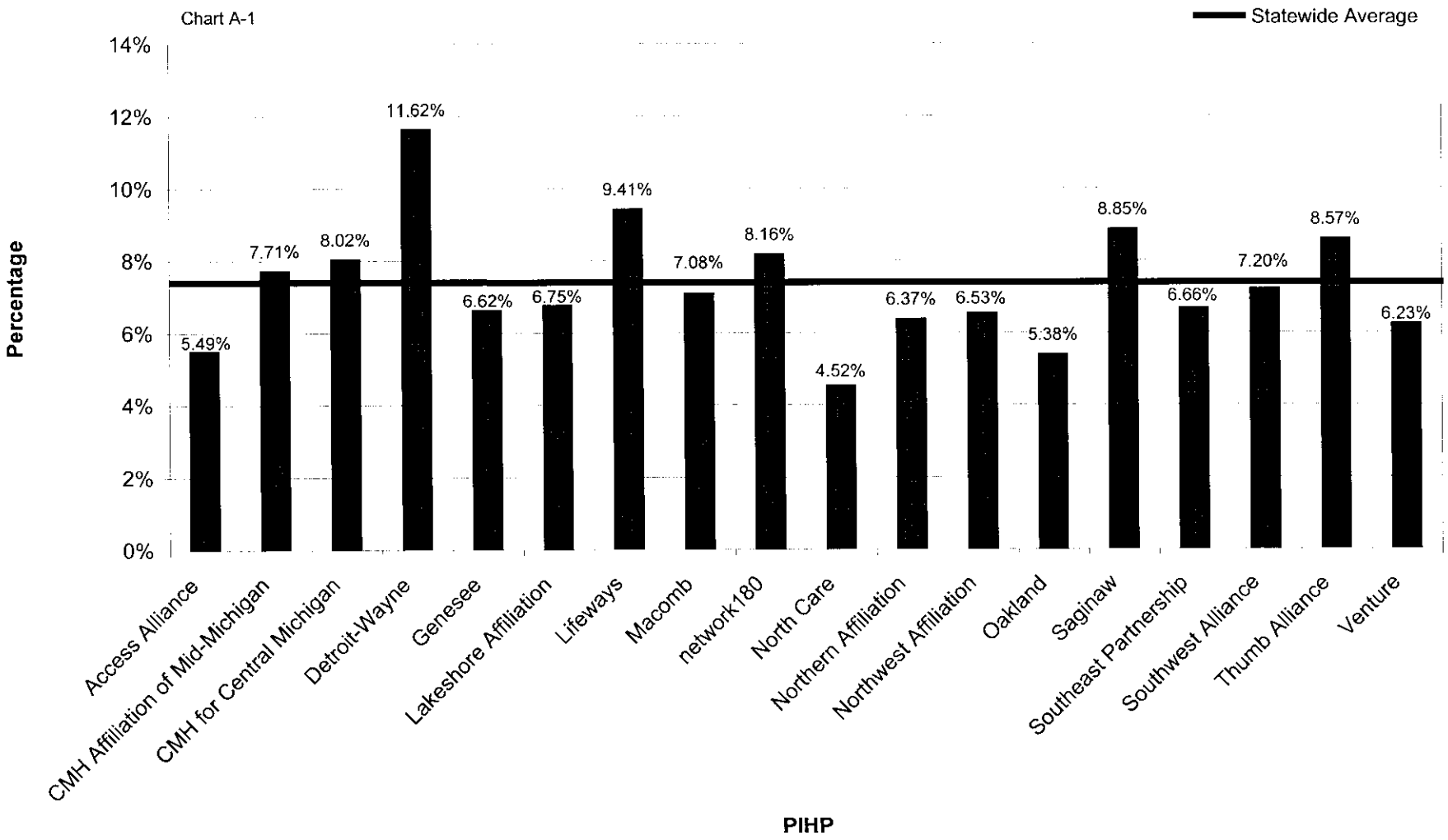
Data Table A-1

PIHP	%	Medicaid Admin Expenditures FY04-05	Gross Medicaid Expenditures FY04-05
Access Alliance	5.49%	$3,233,455	$58,887,324
CMH Affiliation of Mid-Michigan	7.71%	$5,896,828	$76,469,199
CMH for Central Michigan	8.02%	$4,033,953	$50,280,603
Detroit-Wayne	11.62%	$39,133,688	$336,660,065
Genesee	6.62%	$4,789,224	$72,395,367
Lakeshore Affiliation	6.75%	$3,477,892	$51,491,175
Lifeways	9.41%	$2,838,323	$30,155,232
Macomb	7.08%	$7,333,641	$103,612,731
network180	8.16%	$5,338,418	$65,432,856
North Care	4.52%	$2,925,329	$64,716,697
Northern Affiliation	6.37%	$3,025,477	$47,531,652
Northwest Affiliation	6.53%	$2,415,363	$36,966,044
Oakland	5.38%	$9,373,697	$174,308,713
Saginaw	8.85%	$2,881,043	$32,546,110
Southeast Partnership	6.66%	$5,183,860	$77,805,296
Southwest Alliance	7.20%	$4,892,416	$67,903,755
Thumb Alliance	8.57%	$4,613,960	$53,822,545
Venture	6.23%	$3,698,754	$59,369,397
Total	**7.88%**	**$115,085,322**	**$1,460,354,760**
Statewide Average	**7.29%**		

Note 1: Table uses gross administrative costs, which many include spend-down.
Source: Data are taken from Administrative Cost Report, FY05.
v.1.4, 4/4/06

Percent of Medicaid Expenditures Spent on Medicaid Administration by PIHP
Includes Costs Delegated to the Providers, Coordinating Agencies (CA), and Affiliate CMHSPs
FY 2005

Chart A-1



Note 1: Table uses gross administrative costs, which many include spend-down.
Source: Data are taken from Administrative Cost Report, FY05.
v.1.4, 4/4/06

MDCH-DQMP April, 2006

Percent of Medicaid Expenditures Spent on Medicaid Administration by PIHP
Includes Costs Delegated to the Providers, Coordinating Agencies (CA), and Affiliate CMHSPs
FY 2005

Data Table A-2

Group Number	PIHP	%	Medicaid Admin Expenditures FY04-05	Gross Medicaid Expenditures FY04-05
1	CMH for Central Michigan	8.02%	$4,033,953	$50,280,603
1	Genesee	6.62%	$4,789,224	$72,395,367
1	Macomb	7.08%	$7,333,641	$103,612,731
1	Saginaw	8.85%	$2,881,043	$32,546,110
2	Detroit-Wayne	11.62%	$39,133,688	$336,660,065
2	Lifeways	9.41%	$2,838,323	$30,155,232
2	network180	8.16%	$5,338,418	$65,432,856
2	Oakland	5.38%	$9,373,697	$174,308,713
3	Access Alliance	5.49%	$3,233,455	$58,887,324
3	CMH Affiliation of Mid-Michigan	7.71%	$5,896,828	$76,469,199
3	Lakeshore Affiliation	6.75%	$3,477,892	$51,491,175
3	North Care	4.52%	$2,925,329	$64,716,697
3	Northern Affiliation	6.37%	$3,025,477	$47,531,652
3	Northwest Affiliation	6.53%	$2,415,363	$36,966,044
3	Southeast Partnership	6.66%	$5,183,860	$77,805,296
3	Southwest Alliance	7.20%	$4,892,416	$67,903,755
3	Thumb Alliance	8.57%	$4,613,960	$53,822,545
3	Venture	6.23%	$3,698,754	$59,369,397
	Total	**7.88%**	**$115,085,322**	**$1,460,354,760**
	Statewide Average	**7.29%**		

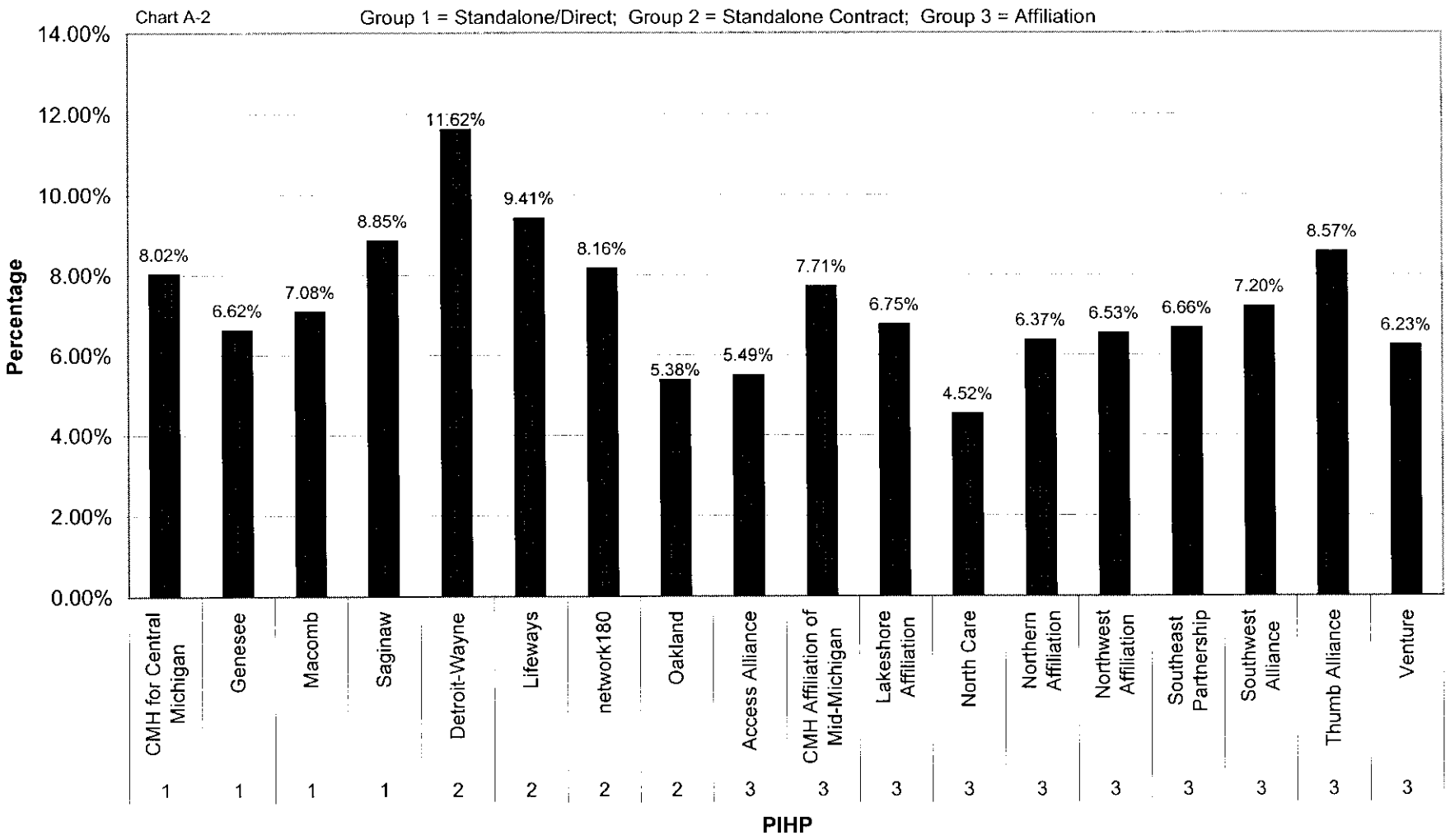
Group 1 = Standalone/Direct; Group 2 = Standalone Contract; Group 3 = Affiliation

Note 1: Table uses gross administrative costs, which many include spend-down.
Source: Data are taken from Administrative Cost Report, FY05.

Percent of Medicaid Expenditures Spent on Medicaid Administration by PIHP

Includes Costs Delegated to the Providers, Coordinating Agencies (CA), and Affiliate CMHSPs

FY 2005



Note 1: Table uses gross administrative costs, which many include spend-down.
Source: Data are taken from Administrative Cost Report, FY05.
v.1.4, 4/4/06

MDCH-DQMP April, 2006

Percent of Medicaid Expenditures Spent on Delegated Medicaid Administration by PIHP's CMH Affiliates, FY 2005

Includes Costs Delegated to the Affiliate CMHSPs

Data Table B

PIHP	CMHSP	%	Affiliate Mental Heath Medicaid Administration FY04-05	Affiliate Mental Health Medicaid Expenditures FY04-05
Access Alliance	Bay-Arenac	3.61%	$924,559	$25,646,312
	Huron	1.86%	$114,319	$6,151,090
	Montcalm	1.23%	$64,234	$5,218,403
	Shiawasee	0.66%	$65,803	$9,945,768
	Tuscola	1.19%	$129,442	$10,869,145
CMH Affiliation of Mid-Michigan	Gratiot	6.34%	$490,527	$7,737,614
	Ionia	0.94%	$64,234	$6,832,495
	Manistee-Benzie	5.80%	$672,732	$11,603,024
	Newaygo	11.32%	$598,318	$5,286,686
Lakeshore Affiliation	Ottawa	4.99%	$1,074,729	$21,534,840
North Care	Copper	2.29%	$231,220	$10,086,362
	Gogebic	3.81%	$168,709	$4,424,483
	Hiawatha	2.35%	$249,017	$10,602,446
	Northpointe	3.28%	$337,419	$10,296,234
Northern Affiliation	AuSable Valley	4.84%	$364,330	$7,524,949
	North Country	4.29%	$869,955	$20,295,983
	Northeast	3.76%	$571,556	$15,201,799
Northwest Affiliation	West Michigan	6.64%	$660,166	$9,948,470
Southeast Partnership	Lenawee	1.53%	$206,189	$13,454,517
	Livingston	1.26%	$148,972	$11,776,544
	Monroe	1.11%	$204,302	$18,343,504
	CSTS	1.49%	$225,539	$15,169,643
Southwest Alliance	Allegan	3.83%	$500,000	$13,045,734
	St. Joseph	3.56%	$300,000	$8,437,614
	Woodlands	3.49%	$200,000	$5,733,157
Thumb Alliance	Lapeer	4.32%	$409,522	$9,480,345
	Sanilac	4.97%	$684,519	$13,776,220
	St. Clair	2.58%	$719,272	$27,838,280
Venture	Barry	1.63%	$48,727	$2,991,445
	Berrien	2.06%	$423,610	$20,553,419
	Pines	4.28%	$267,356	$6,245,885
	Summit Pointe	0.95%	$169,882	$17,835,311
	Van Buren	1.83%	$183,400	$10,039,155
Total		**3.13%**	**$12,342,558**	**$393,926,875**

Source: Data are taken from Administrative Cost Report, FY05.

PIHP Administrative Costs Comparison

Includes Costs Delegated to the Providers, Coordinating Agencies (CA), and Affiliate CMHSPs

FY 2005

Data Table C	Customer Services			Financial Management			General Management			Information Systems Management		
PIHP	Medicaid Admin Expenditures	% of Total Medicaid Admin Expen	% of Gross Medicaid Expen	Medicaid Admin Expenditures	% of Total Medicaid Admin Expen	% of Gross Medicaid Expen	Medicaid Admin Expenditures	% of Total Medicaid Admin Expen	% of Gross Medicaid Expen	Medicaid Admin Expenditures	% of Total Medicaid Admin Expen	% of Gross Medicaid Expen
Access Alliance	$596,456	18.45%	1.01%	$467,720	14.47%	0.79%	$1,174,289	36.32%	1.99%	$305,681	9.45%	0.52%
CMH Affiliation of Mid-Michigan	$499,194	8.47%	0.65%	$998,071	16.93%	1.31%	$370,201	6.28%	0.48%	$624,141	10.58%	0.82%
CMH for Central Michigan	$358,106	8.88%	0.71%	$1,064,254	26.38%	2.12%	$625,037	15.49%	1.24%	$605,773	15.02%	1.20%
Detroit-Wayne	$7,521,847	19.22%	2.23%	$6,221,375	15.90%	1.85%	$4,625,206	11.82%	1.37%	$2,892,478	7.39%	0.86%
Genesee	$1,072,699	22.40%	1.48%	$576,512	12.04%	0.80%	$439,154	9.17%	0.61%	$582,169	12.16%	0.80%
Lakeshore Affiliation	$226,172	6.50%	0.44%	$625,920	18.00%	1.22%	$741,211	21.31%	1.44%	$370,316	10.65%	0.72%
Lifeways	$462,647	16.30%	1.53%	$337,760	11.90%	1.12%	$326,407	11.50%	1.08%	$295,186	10.40%	0.98%
Macomb	$929,251	12.67%	0.90%	$888,730	12.12%	0.86%	$1,347,075	18.37%	1.30%	$668,507	9.12%	0.65%
network180	$594,000	11.13%	0.91%	$494,863	9.27%	0.76%	$470,392	8.81%	0.72%	$510,995	9.57%	0.78%
North Care	$673,302	23.02%	1.04%	$165,915	5.67%	0.26%	$98,736	3.38%	0.15%	$185,330	6.34%	0.29%
Northern Affiliation	$374,247	12.37%	0.79%	$176,161	5.82%	0.37%	$255,408	8.44%	0.54%	$445,935	14.74%	0.94%
Northwest Affiliation	$362,008	14.99%	0.98%	$216,584	8.97%	0.59%	$460,854	19.08%	1.25%	$144,719	5.99%	0.39%
Oakland	$1,810,198	19.31%	1.04%	$891,462	9.51%	0.51%	$864,777	9.23%	0.50%	$1,360,044	14.51%	0.78%
Saginaw	$350,870	12.18%	1.08%	$591,959	20.55%	1.82%	$514,974	17.87%	1.58%	$278,098	9.65%	0.85%
Southeast Partnership	$959,093	18.50%	1.23%	$429,130	8.28%	0.55%	$885,168	17.08%	1.14%	$1,005,290	19.39%	1.29%
Southwest Alliance	$636,531	13.01%	0.94%	$745,081	15.23%	1.10%	$1,034,986	21.15%	1.52%	$389,242	7.96%	0.57%
Thumb Alliance	$911,331	19.75%	1.69%	$431,926	9.36%	0.80%	$479,633	10.40%	0.89%	$316,369	6.86%	0.59%
Venture	$315,111	8.52%	0.53%	$344,372	9.31%	0.58%	$1,255,087	33.93%	2.11%	$442,942	11.98%	0.75%
Total	**$18,653,063**	**16.21%**	**1.28%**	**$15,667,795**	**13.61%**	**1.07%**	**$15,968,595**	**13.88%**	**1.09%**	**$11,423,215**	**9.93%**	**0.78%**

Note 1: Table uses gross administrative costs, which many include spend-down.
Source: Data are taken from Administrative Cost Report, FY05.
v.1.4, 4/4/06

PIHP Administrative Costs Comparison

Includes Costs Delegated to the Providers, Coordinating Agencies (CA), and Affiliate CMHSPs

FY 2005

Data Table C	Provider Network Management			Quality Management			Utilization Management			Total for PIHP		
PIHP	Medicaid Admin Expenditures	% of Total Medicaid Admin Expen	% of Gross Medicaid Expen	Medicaid Admin Expenditures	% of Total Medicaid Admin Expen	% of Gross Medicaid Expen	Medicaid Admin Expenditures	% of Total Medicaid Admin Expen	% of Gross Medicaid Expen	Total Medicaid Admin Expenditures	Gross Medicaid Expenditures	% of Gross Medicaid Expen
Access Alliance	$218,878	6.77%	0.37%	$161,121	4.98%	0.27%	$309,310	9.57%	0.53%	$3,233,455	$58,887,324	5.49%
CMH Affiliation of Mid-Michigan	$851,844	14.45%	1.11%	$632,106	10.72%	0.83%	$1,921,271	32.58%	2.51%	$5,896,828	$76,469,199	7.71%
CMH for Central Michigan	$361,728	8.97%	0.72%	$499,311	12.38%	0.99%	$519,744	12.88%	1.03%	$4,033,953	$50,280,603	8.02%
Detroit-Wayne	$4,631,609	11.84%	1.38%	$3,158,828	8.07%	0.94%	$10,082,345	25.76%	2.99%	$39,133,688	$336,660,065	11.62%
Genesee	$264,350	5.52%	0.37%	$1,190,725	24.86%	1.64%	$663,616	13.86%	0.92%	$4,789,225	$72,395,367	6.62%
Lakeshore Affiliation	$429,083	12.34%	0.83%	$519,595	14.94%	1.01%	$565,595	16.26%	1.10%	$3,477,892	$51,491,175	6.75%
Lifeways	$432,844	15.25%	1.44%	$319,311	11.25%	1.06%	$664,168	23.40%	2.20%	$2,838,323	$30,155,232	9.41%
Macomb	$1,123,548	15.32%	1.08%	$588,047	8.02%	0.57%	$1,788,482	24.39%	1.73%	$7,333,640	$103,612,731	7.08%
network180	$595,599	11.16%	0.91%	$124,857	2.34%	0.19%	$2,547,713	47.72%	3.89%	$5,338,419	$65,432,856	8.16%
North Care	$159,103	5.44%	0.25%	$701,923	23.99%	1.08%	$941,021	32.17%	1.45%	$2,925,330	$64,716,697	4.52%
Northern Affiliation	$391,501	12.94%	0.82%	$259,785	8.59%	0.55%	$1,122,440	37.10%	2.36%	$3,025,477	$47,531,652	6.37%
Northwest Affiliation	$233,735	9.68%	0.63%	$376,000	15.57%	1.02%	$621,463	25.73%	1.68%	$2,415,363	$36,966,044	6.53%
Oakland	$1,715,170	18.30%	0.98%	$1,307,425	13.95%	0.75%	$1,424,621	15.20%	0.82%	$9,373,697	$174,308,713	5.38%
Saginaw	$495,615	17.20%	1.52%	$292,287	10.15%	0.90%	$357,240	12.40%	1.10%	$2,881,043	$32,546,110	8.85%
Southeast Partnership	$195,807	3.78%	0.25%	$98,933	1.91%	0.13%	$1,610,439	31.07%	2.07%	$5,183,860	$77,805,296	6.66%
Southwest Alliance	$605,258	12.37%	0.89%	$369,102	7.54%	0.54%	$1,112,216	22.73%	1.64%	$4,892,416	$67,903,755	7.20%
Thumb Alliance	$911,171	19.75%	1.69%	$610,996	13.24%	1.14%	$952,534	20.64%	1.77%	$4,613,960	$53,822,545	8.57%
Venture	$96,369	2.61%	0.16%	$363,005	9.81%	0.61%	$881,867	23.84%	1.49%	$3,698,753	$59,369,397	6.23%
Total	**$13,713,212**	**11.92%**	**0.94%**	**$11,573,357**	**10.06%**	**0.79%**	**$28,086,085**	**24.40%**	**1.92%**	**$115,085,322**	**$1,460,354,760**	**7.88%**

Note 1: Table uses gross administrative costs, which many include spend-down.
Source: Data are taken from Administrative Cost Report, FY05.
v.1.4, 4/4/06

Percent of Total Administrative Costs that are Delegated, by Functional Area

Includes Costs Delegated to the Providers, Coordinating Agencies (CA), and Affiliate CMHSPs

FY 2005

Data Table D	Customer Services			Financial Management			General Management		
PIHP	Total Delegated Admin Dollars	Medicaid Admin Expenditures	% Delegated of Medicaid Admin Expen	Total Delegated Admin Dollars	Medicaid Admin Expenditures	% Delegated of Medicaid Admin Expen	Total Delegated Admin Dollars	Medicaid Admin Expenditures	% Delegated of Medicaid Admin Expen
Access Alliance	$465,134	$596,456	77.98%	$76,420	$467,720	16.34%	$612,823	$1,174,289	52.19%
CMH Affiliation of Mid-Michigan	$317,668	$499,194	63.64%	$486,069	$998,071	48.70%	$32,560	$370,201	8.80%
CMH for Central Michigan	$7,200	$358,106	2.01%	$7,200	$1,064,254	0.68%	$7,200	$625,037	1.15%
Detroit-Wayne	$2,321,786	$7,521,847	30.87%	$2,737,506	$6,221,375	44.00%	$2,583,489	$4,625,206	55.86%
Genesee	$0	$1,072,699	0.00%	$16,738	$576,512	2.90%	$12,750	$439,154	2.90%
Lakeshore Affiliation	$95,286	$226,172	42.13%	$231,477	$625,920	36.98%	$154,301	$741,211	20.82%
Lifeways	$0	$462,647	0.00%	$0	$337,760	0.00%	$0	$326,407	0.00%
Macomb	$27,820	$929,251	2.99%	$0	$888,730	0.00%	$0	$1,347,075	0.00%
network180	$19,328	$594,000	3.25%	$16,102	$494,863	3.25%	$15,306	$470,392	3.25%
North Care	$276,379	$673,302	41.05%	$17,010	$165,915	10.25%	$5,670	$98,736	5.74%
Northern Affiliation	$308,711	$374,247	82.49%	$77,473	$176,161	43.98%	$79,542	$255,408	31.14%
Northwest Affiliation	$130,287	$362,008	35.99%	$48,703	$216,584	22.49%	$47,453	$460,854	10.30%
Oakland	$326,659	$1,810,198	18.05%	$44,934	$891,462	5.04%	$8,987	$864,777	1.04%
Saginaw	$0	$350,870	0.00%	$0	$591,959	0.00%	$226,495	$514,974	43.98%
Southeast Partnership	$175,145	$959,093	18.26%	$52,000	$429,130	12.12%	$0	$885,168	0.00%
Southwest Alliance	$267,783	$636,531	42.07%	$81,335	$745,081	10.92%	$76,242	$1,034,986	7.37%
Thumb Alliance	$511,472	$911,331	56.12%	$116,857	$431,926	27.05%	$134,990	$479,633	28.14%
Venture	$253,944	$315,111	80.59%	$0	$344,372	0.00%	$155,919	$1,255,087	12.42%
Total	**$5,504,603**	**$18,653,063**	**29.51%**	**$4,009,824**	**$15,667,795**	**25.59%**	**$4,153,727**	**$15,968,595**	**26.01%**

Note 1: Table uses gross administrative costs, which many include spend-down.
Source: Data are taken from Administrative Cost Report, FY05.
v.1.4, 4/4/06

Percent of Total Administrative Costs that are Delegated, by Functional Area

Includes Costs Delegated to the Providers, Coordinating Agencies (CA), and Affiliate CMHSPs

FY 2005

Data Table D	Information Systems Management			Provider Network Management			Quality Management		
PIHP	Total Delegated Admin Dollars	Medicaid Admin Expenditures	% Delegated of Medicaid Admin Expen	Total Delegated Admin Dollars	Medicaid Admin Expenditures	% Delegated of Medicaid Admin Expen	Total Delegated Admin Dollars	Medicaid Admin Expenditures	% Delegated of Medicaid Admin Expen
Access Alliance	$0	$305,681	0.00%	$42,367	$218,878	19.36%	$92,341	$161,121	57.31%
CMH Affiliation of Mid-Michigan	$403,368	$624,141	64.63%	$133,777	$851,844	15.70%	$418,687	$632,106	66.24%
CMH for Central Michigan	$7,200	$605,773	1.19%	$7,200	$361,728	1.99%	$7,200	$499,311	1.44%
Detroit-Wayne	$1,666,000	$2,892,478	57.60%	$1,860,327	$4,631,609	40.17%	$1,206,386	$3,158,828	38.19%
Genesee	$16,902	$582,169	2.90%	$7,675	$264,350	2.90%	$0	$1,190,725	0.00%
Lakeshore Affiliation	$66,604	$370,316	17.99%	$212,088	$429,083	49.43%	$120,244	$519,595	23.14%
Lifeways	$0	$295,186	0.00%	$0	$432,844	0.00%	$0	$319,311	0.00%
Macomb	$0	$668,507	0.00%	$136,190	$1,123,548	12.12%	$0	$588,047	0.00%
network180	$16,627	$510,995	3.25%	$19,380	$595,599	3.25%	$4,063	$124,857	3.25%
North Care	$8,505	$185,330	4.59%	$14,175	$159,103	8.91%	$294,676	$701,923	41.98%
Northern Affiliation	$65,001	$445,935	14.58%	$339,499	$391,501	86.72%	$110,620	$259,785	42.58%
Northwest Affiliation	$68,708	$144,719	47.48%	$119,276	$233,735	51.03%	$178,525	$376,000	47.48%
Oakland	$26,960	$1,360,044	1.98%	$744,772	$1,715,170	43.42%	$686,758	$1,307,425	52.53%
Saginaw	$0	$278,098	0.00%	$0	$495,615	0.00%	$0	$292,287	0.00%
Southeast Partnership	$478,268	$1,005,290	47.58%	$13,184	$195,807	6.73%	$0	$98,933	0.00%
Southwest Alliance	$20,494	$389,242	5.27%	$125,886	$605,258	20.80%	$74,104	$369,102	20.08%
Thumb Alliance	$48,502	$316,369	15.33%	$651,844	$911,171	71.54%	$96,702	$610,996	15.83%
Venture	$0	$442,942	0.00%	$0	$96,369	0.00%	$255,264	$363,005	70.32%
Total	**$2,893,139**	**$11,423,215**	**25.33%**	**$4,427,640**	**$13,713,212**	**32.29%**	**$3,545,570**	**$11,573,357**	**30.64%**

Note 1: Table uses gross administrative costs, which many include spend-down.
Source: Data are taken from Administrative Cost Report, FY05.
v.1.4, 4/4/06

Percent of Total Administrative Costs that are Delegated, by Functional Area

Includes Costs Delegated to the Providers, Coordinating Agencies (CA), and Affiliate CMHSPs

FY 2005

Data Table D	Utilization Management			Total for PIHP				
PIHP	Total Delegated Admin Dollars	Medicaid Admin Expenditures	% Delegated of Medicaid Admin Expen	Total Delegated Admin Dollars	Total Medicaid Admin Expenditures	% Delegated of Total Medicaid Admin Expen	Gross Medicaid Expenditures	% Delegated of Gross Medicaid Expen
Access Alliance	$9,272	$309,310	3.00%	$1,298,357	$3,233,455	40.15%	$58,887,324	2.20%
CMH Affiliation of Mid-Michigan	$697,286	$1,921,271	36.29%	$2,489,415	$5,896,828	42.22%	$76,469,199	3.26%
CMH for Central Michigan	$7,200	$519,744	1.39%	$50,400	$4,033,953	1.25%	$50,280,603	0.10%
Detroit-Wayne	$3,949,286	$10,082,345	39.17%	$16,324,780	$39,133,688	41.72%	$336,660,065	4.85%
Genesee	$19,267	$663,616	2.90%	$73,332	$4,789,225	1.53%	$72,395,367	0.10%
Lakeshore Affiliation	$267,610	$565,595	47.31%	$1,147,610	$3,477,892	33.00%	$51,491,175	2.23%
Lifeways	$0	$664,168	0.00%	$0	$2,838,323	0.00%	$30,155,232	0.00%
Macomb	$257,919	$1,788,482	14.42%	$421,929	$7,333,640	5.75%	$103,612,731	0.41%
network180	$82,898	$2,547,713	3.25%	$173,704	$5,338,419	3.25%	$65,432,856	0.27%
North Care	$426,651	$941,021	45.34%	$1,043,066	$2,925,330	35.66%	$64,716,697	1.61%
Northern Affiliation	$889,434	$1,122,440	79.24%	$1,870,280	$3,025,477	61.82%	$47,531,652	3.93%
Northwest Affiliation	$127,940	$621,463	20.59%	$720,892	$2,415,363	29.85%	$36,966,044	1.95%
Oakland	$1,084,939	$1,424,621	76.16%	$2,924,009	$9,373,697	31.19%	$174,308,713	1.68%
Saginaw	$0	$357,240	0.00%	$226,495	$2,881,043	7.86%	$32,546,110	0.70%
Southeast Partnership	$258,777	$1,610,439	16.07%	$977,374	$5,183,860	18.85%	$77,805,296	1.26%
Southwest Alliance	$559,097	$1,112,216	50.27%	$1,204,941	$4,892,416	24.63%	$67,903,755	1.77%
Thumb Alliance	$286,033	$952,534	30.03%	$1,846,400	$4,613,960	40.02%	$53,822,545	3.43%
Venture	$583,766	$881,867	66.20%	$1,248,893	$3,698,754	33.77%	$59,369,397	2.10%
Total	**$9,507,374**	**$28,086,085**	**33.85%**	**$34,041,876**	**$115,085,323**	**29.58%**	**$1,460,354,760**	**2.33%**

Note 1: Table uses gross administrative costs, which many include spend-down.
Source: Data are taken from Administrative Cost Report, FY05.
v.1.4, 4/4/06

Percentage of Total Administrative Costs that are Delegated

Includes Costs Delegated to the Providers, Coordinating Agencies (CA), and Affiliate CMHSPs

FY 2005

Data Table E

PIHP	% Delegated	Total PIHP Admin Delegated Costs	Total PIHP Admin Costs
Access Alliance	40.15%	$1,298,357	$3,233,455
CMH Affiliation of Mid-Michigan	42.22%	$2,489,415	$5,896,828
CMH for Central Michigan	1.25%	$50,400	$4,033,953
Detroit-Wayne	41.72%	$16,324,780	$39,133,688
Genesee	1.53%	$73,332	$4,789,225
Lakeshore Affiliation	33.00%	$1,147,610	$3,477,892
Lifeways	0.00%	$0	$2,838,323
Macomb	5.75%	$421,929	$7,333,640
network180	3.25%	$173,704	$5,338,419
North Care	35.66%	$1,043,066	$2,925,330
Northern Affiliation	61.82%	$1,870,280	$3,025,477
Northwest Affiliation	29.85%	$720,892	$2,415,363
Oakland	31.19%	$2,924,009	$9,373,697
Saginaw	7.86%	$226,495	$2,881,043
Southeast Partnership	18.85%	$977,374	$5,183,860
Southwest Alliance	24.63%	$1,204,941	$4,892,416
Thumb Alliance	40.02%	$1,846,400	$4,613,960
Venture	33.77%	$1,248,893	$3,698,754
Total	**29.58%**	**$34,041,877**	**$115,085,323**
Statewide Average	**25.14%**		

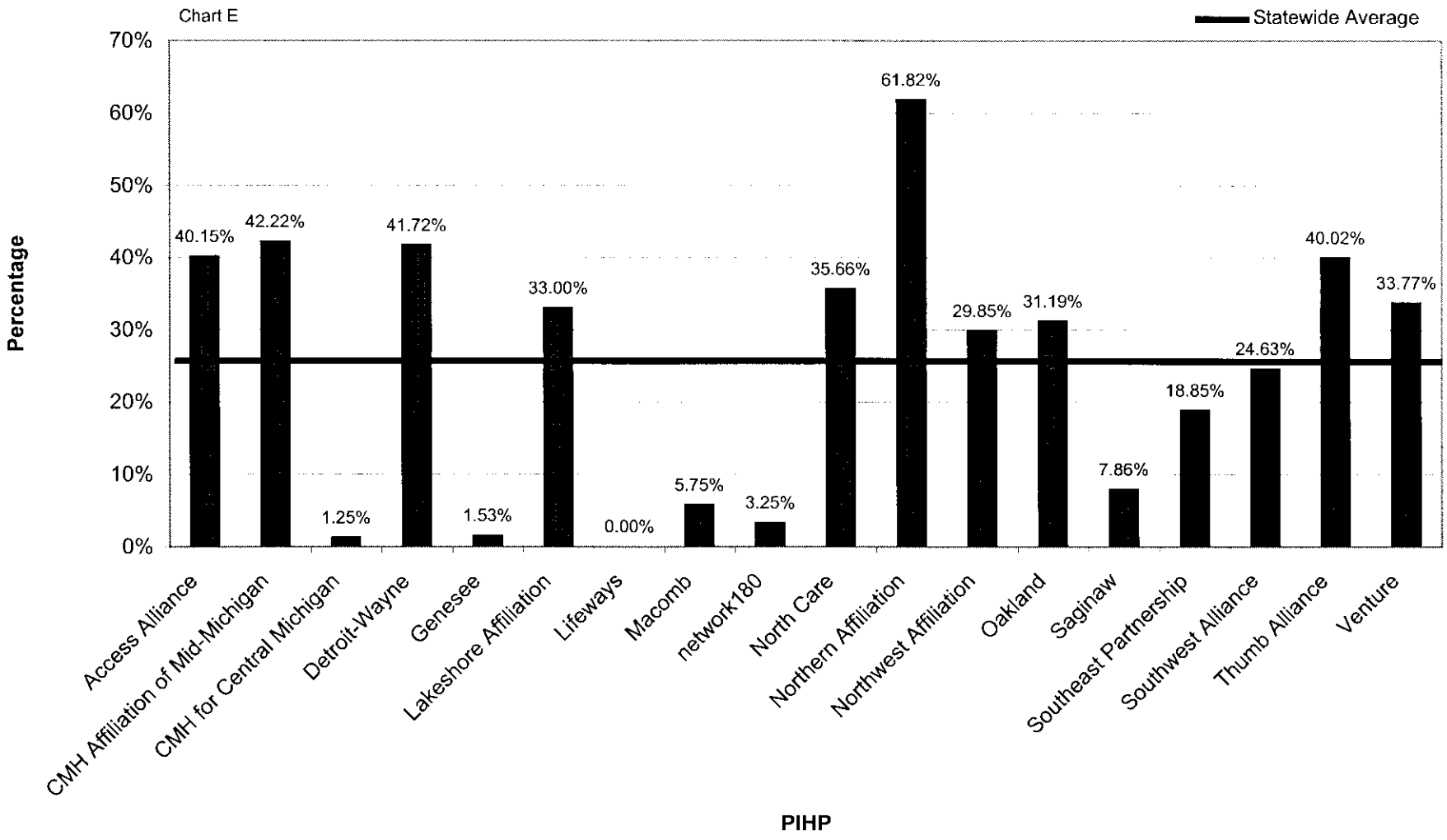
Note 1: Table uses gross administrative costs, which many include spend-down.

Source: Data are taken from Administrative Cost Report, FY05.

Percentage of Total Administrative Costs that are Delegated, by PIHP

Includes Costs Delegated to the Providers, Coordinating Agencies (CA), and Affiliate CMHSPs

FY 2005



Note 1: Table uses gross administrative costs, which many include spend-down.
Source: Data are taken from Administrative Cost Report, FY05.
v.1.4, 4/4/06

Comparison of FY 2004 and FY 2005
Administrative and Total Costs

Data Table G

PIHP Name	FY 2004 Administrative Cost	FY 2004 Total Cost	FY 2004 Percentage of Admin Expenditures	FY 2005 Administrative Cost	FY 2005 Total Cost	FY 2005 Percentage of Admin Expenditures
Access Alliance	$4,145,792	$54,479,336	7.61%	$3,233,455	$58,887,324	5.49%
CMH Affiliation of Mid-Michigan	$5,560,755	$74,755,283	7.44%	$5,896,828	$76,469,199	7.71%
CMH for Central Michigan	$3,176,946	$47,248,049	6.72%	$4,033,953	$50,280,603	8.02%
Detroit-Wayne	$36,316,604	$328,543,677	11.05%	$39,133,688	$336,660,065	11.62%
Genesee	$5,323,287	$64,122,941	8.30%	$4,789,224	$72,395,367	6.62%
Lakeshore Affiliation	$3,367,925	$48,873,681	6.89%	$3,477,892	$51,491,175	6.75%
Lifeways	$2,909,218	$26,095,948	11.15%	$2,838,323	$30,155,232	9.41%
Macomb	$6,338,157	$98,495,114	6.43%	$7,333,641	$103,612,731	7.08%
network180	$4,738,811	$62,246,108	7.61%	$5,338,418	$65,432,856	8.16%
North Care	$4,435,108	$63,481,215	6.99%	$2,925,329	$64,716,697	4.52%
Northern Affiliation	$2,375,467	$47,204,526	5.03%	$3,025,477	$47,531,652	6.37%
Northwest Affiliation	$2,426,132	$39,690,201	6.11%	$2,415,363	$36,966,044	6.53%
Oakland	$8,947,877	$160,662,825	5.57%	$9,373,697	$174,308,713	5.38%
Saginaw	$2,759,985	$26,557,124	10.39%	$2,881,043	$32,546,110	8.85%
Southeast Partnership	$5,408,411	$69,921,076	7.74%	$5,183,860	$77,805,296	6.66%
Southwest Alliance	$4,376,313	$64,677,104	6.77%	$4,892,416	$67,903,755	7.20%
Thumb Alliance	$4,425,121	$53,237,614	8.31%	$4,613,960	$53,822,545	8.57%
Venture	$3,704,315	$60,767,772	6.10%	$3,698,754	$59,369,397	6.23%
Total	**$110,736,224**	**$1,391,059,594**	**7.96%**	**$115,085,322**	**$1,460,354,760**	**7.88%**

Source: Fy 2004 PIHP SE-Cost Reports FY 2005 Administrative Cost Report
v.1.4, 4/4/06